Exhibit 5

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF UTAH, CENTRAL DIVISION

* * *

MARTIN CROWSON,

Plaintiff,

vs.

WASHINGTON COUNTY, et al.,

Defendants.

Case No. 2:15-cv-00880

Deposition of:

MICHAEL T. JOHNSON

* * *

ORIGINAL

April 17, 2018

9:00 a.m.

WASHINGTON COUNTY TREASURER OFFICE
197 East Tabernacle Street
St. George, Utah

* * *

Linda Van Tassell
- Registered Diplomate Reporter -
Certified Realtime Reporter

Tuesday or Thursday, depending on his schedule with his other stuff.

Q. Okay. What do you do when Dr. Larrowe is not on site but you need a doctor's input?

A. We call him directly. We have an access line to him directly through a cell phone we use at the jail. Also, if we need to call his office, his clinic or his own cell phone, he's available to us 24/7 that way. If he's not, he usually designates one of his nurse practitioners to be on call for him if he's out of town or not available.

Q. What types of medical issues do you deal with?

A. It's a broad range. Everything from a head cold to an assault in the jail or someone having a heart attack. It covers everything.

Q. So whatever medical issue comes up --

A. We're the first ones that deal with it.

Q. When you're on shift how many nurses are on shift?

A. Monday through Thursday we usually have two. Back then, it varied a little bit. We've had ongoing issues with staffing, like any other place. I think Monday through Thursday we try and have two nurses on and Friday, Saturday, Sunday it's usually

scheduled appropriately. There's also a dentist that comes out once a week so we're involved in that a little bit just to make sure patients get down there and fill out the paperwork they need.

Q. All right. The charting you do, is that done in CorEMR?

A. Yes.

Q. Is there anywhere else that you do charting?

A. No.

Q. Any paper charts?

A. No.

Q. Paper files?

A. No.

Q. Paper medical records?

A. No, not at that time, I don't believe so. We've had CorEMR for a long time out there.

Q. Do you have access to Spillman?

A. I've got access to put entries in through whatever password I've got and usually that entails basically just dietary things, if I order certain -- like a diabetic would have a diet specific to them, vegetarian stuff, just to coordinate with the kitchen. To put in actual Spillman entries for inmates like the deputies do, I

Q. Is there ever a situation where you meet with an inmate out in the corridor or in the cell block?

A. On occasion, yeah. If they get pulled out from the cell block in their interaction with the deputy, sometimes they'll have us come down, say, "Hey, this guy is not acting right or this guy is having problems. Can you come down to see if we need to move him or what we need to do with him." So on occasion there is, yeah.

Q. What training do you have in regard to recognizing brain injuries?

A. As an RN. Just what I've been through at school and through experience.

Q. What would you list off as the things you're looking for to identify brain injury?

A. There's neuro checks, neurological assessment. Usually check their eyes, their movement, their speech, their cognitive, whether they're processing, either slow or fast, or if they're having some kind of a manic episode. We check their grips. With neurological assessment you go kind of head to toe. Have them stick their tongue out, wiggle it back and forth, check their eyes, see if they're dilated, pinpoints, if they can

move their eyes, track with their eyes, if they can answer questions, if they can speak clearly enough. Those are all assessment tools to do that with.

Q. Okay. And what are the different causes of a brain injury?

MR. MYLAR: Objection. Lack of foundation. You can go ahead and answer.

A. Trauma. There's multiple things that can cause brain injury.

Q. I'm making you do the work. I'll list them off for you, how's that?

A. Okay.

Q. Is trauma a cause of brain injury?

A. Yes.

Q. Heart attack?

A. Yes.

Q. Stroke?

A. Yes. Can be.

Q. Kidney disease?

A. Can be.

Q. Liver issues?

A. I don't know on that one.

Q. Infection?

A. Can be.

Q. Alcohol withdrawal?

the essence for inmates?

A. It can be. Depends on the severity.

Q. And how do you determine severity?

A. Do all the assessments I just mentioned, get it off to the doctor immediately, call him and make sure he's aware of what's going on.

Q. In the 14 years you've been there, how many times have you sent somebody off to the emergency room because of a brain injury?

A. That's hard to say. Specific to a brain injury -- we've had concussions that have been diagnosed and we've sent them off. It has to do with a doctor's order. If the doctor orders us to send them, we send them.

Q. Do you guys follow any specific criteria for determining the severity of a brain injury?

A. Could you clarify that? I'm not sure what you're asking.

Q. Are there any guides or written policies --

A. Not that I'm aware of.

Q. -- where you give a score or numerical value to the severity of a brain injury?

A. There's a few scores we can use like a Glasgow Coma Scale and just -- like I say, when we

Q. Is that because brain injuries are serious?

A. Brain injuries are serious, yeah.

Q. And time is of the essence in treating them, right?

A. Can be, yes.

Q. Can be, what do you mean by that?

A. I just mean depending on -- I don't diagnose. I'm not -- that's not my field. The doctor diagnoses. I just assess and I pass that information on.

Q. Okay. I'm going to switch here a little bit to alcohol withdrawal.

A. Okay.

Q. What do you do to assess whether someone is suffering from alcohol withdrawal?

A. Cognitive is important, neurological, if they can ambulate, eat, talk without having any problems. Vital signs are important. Heart rate is very important. Shakes, a lot of times they'll have symptoms of shakes, especially with alcoholics, so we try to watch those carefully.

Q. Heart rate, what does heart rate tell you?

A. If it's elevated, it's usually -- they

can be symptomatic of a patient having either a seizure. And most of the time with alcohol, DTs or delirium tremens, that's the main thing we worry about is a seizure.

Q. Delirium tremens, is that when they have the shakes?

A. At times, yeah. Not always.

Q. If you had delirium tremens and elevated heart rate then you're at risk for seizure?

A. That's the risk they have, yeah. It can be risk for it.

Q. As far as other symptoms of delirium tremens, how do you know if someone is having that?

A. You monitor their vital signs, their cognitive. Like I say, if they can eat, ambulate, they usually have problems with that if they're having those issues.

Q. Elevated blood pressure?

A. Sometimes, yes.

Q. Decrease in blood pressure?

A. Can be, yeah.

Q. Is it your understanding that alcohol withdrawals typically begin 48 to 72 hours after the person last had alcohol?

A. They can have them quicker than that.

I've seen them have them quicker than that. Just depends. Depends on the person.

Q. Is it your understanding that the symptoms of alcohol withdrawal typically peak within 24 to 36 hours?

A. Most of the time.

Q. All right. I want to ask you about Mr. Crowson. Do you have a memory of him?

A. I didn't when this was first -- when I was first served. I had to go back and look at the documentation and see.

Q. What documentation did you look at?

A. My notes.

Q. Those are notes in CorEMR?

A. Uh-huh.

Q. Did you have any other notes?

A. Pardon me?

Q. Do you have any other notes?

A. No.

Q. Do you now recall Mr. Crowson?

A. Somewhat, yeah. The name is familiar because he's been in and out of the jail a few times.

Q. Do you know what he looks like?

A. No.

Q. Once an entry has been made, can it be edited?

A. Not that I know of. I don't know.

Q. You've never edited anything there?

A. No.

Q. If there's a change, you notice something that needs to be recorded differently, do you just do a separate entry?

A. Yes.

Q. Okay. The interview date, is there any way to change that date after it's been entered?

A. Not that I'm aware of.

Q. Okay. I'm going to flip here to 481 where it starts with the booking number 136931. The date on this is June 25, 2014 at 7:15 a.m. and you're listed as the interviewer. Here in the item response form it says, "Confused. Different affect than is normally displayed."

A. Okay.

Q. As you sit here right now, do you know how you knew it was different than normal?

A. From the deputies. When they report they say he's acting different than he normally does.

Q. I'll represent to you there are notes in

Q. What does that stand for?

A. And a-n-d.

Q. "Patient safety and further eval with J. Worlton."

A. Yes.

Q. At that point you recognized that there was a mental health issue happening?

A. There was some kind of issue happening. That's why I recommended him to Jon Worlton. Like the note says, he's acting a little bit different toward the deputies. And the way I remember Mr. Crowson, he was more outgoing, not quiet, reserved. Outgoing, interactive.

Q. Okay. I want to skip down here to this line. "Booking staff," Q, does that stand for question?

A. No. It stands for every.

Q. "Booking staff every 30 minutes." That means you wanted them to look at him every 30 minutes?

A. They do cell checks every 30 minutes in booking on each individual.

Q. Is this a detox cell we're referring to?

A. It's every cell in booking. They check every 30 minutes.

A. Yes.

Q. Did you also recognize that it was an issue that was outside the scope of what you were comfortable doing on your own?

A. Yes.

Q. The entry on page 483 is for an earlier incarceration that's dated 12-28, 2011, and this one was for a detox observation.

A. Okay.

Q. You have a choice, don't you? You can put them in for detox observation or you can put them in for mental health observation?

A. Yes.

Q. And those are two separate things.

A. Yes.

Q. And on June 25, 2014, if you had thought it was detox, you could have put him in for detox observation, correct?

A. Yes.

Q. But you didn't. You put him in for mental health observation.

A. That was my first exam.

Q. All right. 487, right here in the middle of the page, do you recognize what type of entry that is in CorEMR? See this middle box right

Q. Okay. When you looked at the records here in CorEMR did you pull them up using Mr. Crowson's name or did you pull them up using entries that you made for that time period or a different way? How did you do it?

A. Pulled them up using Mr. Crowson's name and I just looked at my own to review.

Q. You didn't look at anything written by Mr. Borrowman or anyone else?

A. No.

Q. Are you familiar with the CIWA-AR standards for alcohol withdrawal symptoms?

A. No.

Q. Is that something you've learned about or discussed at National Correctional Nursing Association?

A. I've heard of it and I've probably attended training on it before but I don't remember right now.

Q. Nothing you recall?

A. No.

Q. Is that no?

A. No.

Q. That's the worst way to ask that question. Do you follow the CIWA-AR standards for

rating alcohol withdrawal symptoms?

A. We follow what we've been trained to do by Dr. Larrowe in the jail. Right now I couldn't tell you what those are.

Q. Okay. What do you do to rate the severity of alcohol withdrawal symptoms in jail as you've been trained?

A. We do an initial assessment. We would take vital signs, we'll check neuros, we'll check if there's any signs or symptoms of delirium tremens, shakes, cognitive issues, anything that would seem to be abnormal.

Q. Okay. I'm going to ask you some questions and I want you to tell me if that's the function of the nurse in the jail or if it's the function of someone, okay? I'm going to ask you questions specifically about evaluating potential brain injuries.

First off, you'd agree if you're diagnosing a brain injury it would be a good idea to find out if a person is having headache or head pain, correct?

MR. MYLAR: Objection. Lack of foundation. He's already testified he doesn't diagnose.

Mr. Crowson had been in lockdown for at least seven days?

A. No.

MR. MYLAR: How much longer are you going to go? I just wonder if we could take a break.

(Recess.)

Q. Before we went off the record we were having a discussion about diagnosing or assessing for brain injuries. In that policy or procedures manual is there anything in there that says, "Hey, if you get somebody with decreased mental status or changed mental status you should go through this list of evaluations to see if they have a brain injury."

A. Not that I'm aware of.

Q. No policy at all.

A. I don't know.

Q. Okay. Have you ever been through any training with Dr. Larrowe where he said, "If you've got a patient with changed mental status, I want you to go through these criteria to determine if there's a brain injury."

A. No.

Q. Ever had discussion with Dr. Larrowe

A. It depends on who -- for me, I would call the doctor if he was that way for 24 hours, yes.

Q. Okay. I'm assuming that would be the same answer for 48, 72, 86 and --

A. Yes.

Q. Every day.

A. Yes.

Q. Every new day that he's still dazed and confused is another day that the doctor should be called.

A. Yes. Or made aware of the situation to see if we need to do further observation or further vital signs or whatever.

Q. Okay. If he's unable to follow simple instructions like get dressed, that's another reason that a doctor should be contacted, correct?

A. Not necessarily. I'm not sure what you're asking me there.

Q. Okay. Well --

A. Just because somebody doesn't want to get dressed doesn't mean I'm going to call the doctor.

Q. Hypothetically, if the deputy takes a stack of clothes in to him and he says, "Get

on that, are they?

A. It's usually gone through medical to get ahold of Dr. Larrowe.

Q. And Mr. Crowson, assuming he was able, couldn't call Dr. Larrowe directly, could he?

A. No.

Q. When you were working at Dixie Regional Medical Center one of the important things you would do as a nurse is take medical history of a patient, right?

A. Yes.

Q. Hypothetically, you're in the emergency room and a patient comes in with a situation, an emergent situation. Do you take a new history of that patient or do you rely on a history that was given two weeks prior?

MR. MYLAR: Objection. Lack of foundation. Also incomplete hypothetical and the hypothetical has no relationship to the facts in this case. Go ahead.

A. And you understand this is in a jail setting. I didn't view this patient's intake when he came in two weeks prior so I don't know.

Q. And on 6-25-14 you didn't look at his intake either, did you?

Q. Wouldn't you have sent him to the emergency room at that point?

A. Not without a doctor's order. I reported back I believe it says here. His lung sounds were good. He was doing okay breathing but he wouldn't take any deep breaths. His vital signs were actually better with his blood pressure. He had an elevated heart rate still so we were continuing to monitor him.

Q. Now you're looking at the entry dated June 20, 2014 at 4:24 p.m.

A. That's correct. That's just before the end of my shift.

Q. At this point he's been under medical observation for three days and you told him to breathe deep and he said he would, but he didn't.

A. No.

Q. Why didn't you recommend that Dr. Larrowe send him to the emergency room at that point?

MR. MYLAR: I'm going to object as to vagueness, recommend. I'm not sure what you mean by that.

A. Yeah. Like I stated, it was the end of the shift, it was close to the end of the shift. I

probably gave report to the next nurse and that was what we did.

Q. If that was your kid, would you want him to go to the hospital?

MR. MYLAR: Objection. Incomplete hypothetical. Calls for speculation.

A. We were continuing just to monitor him, keep track of him at that time.

Q. Okay. If that was your kid who has been dazed and confused for three days you would send him to the hospital, wouldn't you?

MR. MYLAR: Objection. No foundation. Calls for speculation and incomplete hypothetical.

A. I don't know if I would. I don't know.

Q. If that was your wife who had been dazed and confused for three days --

A. If it was the same situation and he was under medical care and in jail, I would trust them to take care of him.

Q. I'm not asking in jail. I'm asking about real people outside of jail. If that was your wife --

A. This is a different situation than outside of jail.

Q. Why is it different?

A. I'm not sure what you're getting at as far as different.

Q. I'm saying the fact of the matter is inmates don't get the same care as people on the outside, do they?

MR. MYLAR: Objection. Argumentative.

MR. WIGHT: Go ahead.

A. Ask me the question again, please.

MR. MYLAR: Also object on vagueness.

A. I'm not sure what you're getting at.

Q. If this was somebody that you knew and cared about, you would not be satisfied with that care.

MR. MYLAR: Objection. Again incomplete hypothetical. Calls for speculation.

A. Again, I don't know what you're trying to ask me.

Q. I'm asking you based on the symptoms.

A. You said just a few minutes ago that inmates don't get the same care. It's a different setting in the jail. It's not different in the care they get. It's just a different setting. We had orders from the doc to observe this patient, make sure if there was anything else going on and that's what we were doing.

Q. And that's what you were doing?
A. Yeah.
Q. And the fact that he had been dazed and confused for three days and couldn't follow a simple instruction like take a deep breath, that didn't cause any alarm bells to go off?
MR. MYLAR: Objection. Lack of foundation. We don't have knowledge of three days. He's already admitted he's not there.
MR. SCHRIEVER: So this is the third day. He was there on the third day.
A. I was there for my shift, yes, and during my shift we were monitoring him. If he at any time would have had more of an issue other than just dazed and confused then, yes, if the doctor would have ordered it we would have sent him out to the ER. I can't answer for any of the other time that I wasn't there.
Q. And I'm not asking you to second guess what the doctor did or did not order.
A. I'm not saying I am. I'm just saying I can only answer your questions according to what I charted and what I was there for. Three days dazed and confused, you're trying to lump that into a whole three days that I wasn't there that whole

three days. I was only there for my shifts.

Q. So did it matter at all to you then what's going on during the two days you weren't there?

A. I charted it and I reported it to the doctor.

Q. Okay. At that point are you making the assumption that it hadn't been going on consistently for --

A. I'm not assuming anything.

Q. As a nurse who is charged with the healthcare of that patient, shouldn't you be assuming it's important to know whether he had been dazed and confused for three solid days at that point?

MR. MYLAR: Objection. Lack of foundation.

A. I'm still not sure what you're trying to ask me. You're trying to ask me to speculate. I can't speculate on the other time I wasn't there.

Q. Let me ask you this. Was it important or was it not important to you -- it's not speculating.

A. In my mind --

MR. MYLAR: Wait, wait, wait. Excuse

Q. So if there's a situation where the inmate should be sent to a hospital, the only way Dr. Larrowe is going to know that is if you tell him, right?

MR. MYLAR: Objection. Incomplete hypothetical. Lack of foundation. Calls for speculation.

A. I don't know what you're getting at.

Q. How is it Dr. Larrowe sends them to a hospital unless you tell him?

MR. MYLAR: Objection. Calls for a mental impression on Dr. Larrowe and calls for speculation and lack of foundation of my client.

A. For the time I'm there that's the only time I can speak for. For the other two days or whatever when he was there, I can't talk for that. I don't know.

Q. When you're there, the only way Dr. Larrowe would know whether to send a patient to a hospital is if you tell him, right?

A. I don't tell Dr. Larrowe to send anybody to a hospital. I give him what we're observing and he makes that determination.

Q. You never recall where you said to Dr. Larrowe, "Hey, I think this guy should go to a

hospital." Am I understanding that correctly?

A. There was never a call.

Q. You've never had a call to Dr. Larrowe where you said, "Hey, I think we should send this guy to the hospital."

A. If I thought at this point he needed to go, I would have given the information that I had to Dr. Larrowe and let him make that determination.

Q. Would you have made a recommendation -- let me back up. Is it within your ability to make a direct recommendation to Dr. Larrowe that he send an inmate to the emergency room?

A. Within my ability?

Q. Yes.

A. That would mean I would diagnose the patient and I wouldn't diagnose the patient. I would just give him what I was observing and what information I had and let him determine that.

Q. Is it within your ability to call Dr. Larrowe and recommend that you take a blood draw from the inmate?

A. I would give him information that I'm seeing and let him determine if a blood draw was needed.

Q. Would Dr. Larrowe ever ask you, "Hey,

methamphetamine. It can be a longer period. Depends on the individual. Everybody is a little bit different that way.

Q. DTs, the delirium tremens that you noted on the 29th, do you remember how those manifested?

A. Not specifically. He would have had the shakes. He would have maybe been sweating. Vital signs are off again. He's a little confused after that amount of time.

Q. If he was sweaty, you would note that, wouldn't you?

A. Perhaps; perhaps not.

Q. Would you consider that to be an important symptom?

A. If it was happening in this case.

Q. Delirium tremens would also be different from person to person, right?

A. Yes.

Q. It can be very severe shakes?

A. Yes.

Q. It can also be so mild you would have to touch his fingertip to see if they're shaking, right?

A. You would have to do a neuro check, check his vital signs, maybe do a manual pulse.

Q. Page 502, a category called scanned documents. It looks like July 3, 2014 there were some documents downloaded by Elizabeth Jimenez and they were medical records from Dixie Regional Medical Center. Do you know how the jail came into possession of the Dixie Regional Medical Center records?

A. Probably requested them.

Q. Okay. Is that something as a nurse you do or is that someone else's job to request records?

A. We will request records at time if there's a need. Sometimes we get them, sometimes we don't. Sometimes they're delayed in getting to us.

Q. Have you ever had an opportunity to look at what records were downloaded?

A. No. I believe he was released on the 2nd; is that right? From our custody?

Q. From your custody, yes.

A. And then we received these on the 3rd, so I wouldn't have looked at them.

Q. Okay.

(Discussion off the record.)

Q. On July 30th there was an x-ray done to rule out pneumonia is what the record states.

MR. MYLAR: July 30th?

back a page. So on page 498 does this indicate that you met with Mr. Crowson on the 30th?

A. No. He wasn't in my care. Like I said, Ryan and I were both on that day. Ryan had booking. I had general population.

Q. When somebody exhibits those symptoms, is it important to take vital signs regularly?

A. At least once a shift, yeah. Check on him twice a day.

Q. If vital signs are taken, it should be recorded in CorEMR every time?

A. Should.

Q. Who is Trevor Benson?

A. Right now he's a lieutenant over housing.

Q. Who was he in June of 2014?

A. I'm not sure what his assignment was.

Q. How about Harry Lambert?

A. He was a lieutenant.

Q. 513, this note is dated 8-11-14 and it recites down here that Crowson was transported on July 14th and then it gives a description. Have you ever seen this report before?

A. No.

Q. Were you ever asked by Trevor Benson or

training?

A. Not exactly, no.

Q. Was it after this June of 2014 or before? Any way to tell me that?

A. I don't know.

Q. I want to go back to 501. Specifically I want to start with the June 25th entry. It's my understanding that the June 25, 2014 entry at 7:13 a.m., this is something that you entered, correct?

A. Yes.

Q. I don't see anywhere in this entry that it states that you contacted Dr. Larrowe. Am I missing it somehow?

A. No. Not at that point I didn't get ahold of him.

Q. So you don't believe you contacted him on June 25th?

A. I don't believe so.

Q. All right. You do know that you referred Mr. Crowson to Jon Worlton, though.

A. Yes.

Q. But I think, and I just want to make sure your testimony is you're not sure what happened with that referral.

A. No.

Q. You already told us that you weren't at the facility on the 26th or the 27th. Do you know what nurses were at the facility those days?

A. Not specifically.

Q. If the nurses that were there the 26th and the 27th had entered notes in CorEMR, would you expect that we would see those here on 501?

A. Should be there.

Q. And you've never become aware of any notes that were entered those days?

A. No.

Q. So the first note I see of a contact with Dr. Larrowe was June 28, 2014, 4:22 p.m. Does that look accurate to you?

A. June 28 what time?

Q. 4:22 p.m. It says, "Patient status, staffed with M.D."

A. I reported to the doctor at 2:00, 2:07 on the 28th.

Q. Oh, I see. You're right. That was the first time you contacted Dr. Larrowe?

A. Yes.

Q. Okay. Do you have any actual memory of the conversations you had with Dr. Larrowe on the 28th of June?

right.

Q. And you were aware of that at the time, in the June 25th timeframe?

A. Yeah. He had been out there before and we knew he was a user, was a drug user and had problems.

Q. You testified earlier that when you tried to take his blood you had trouble and one of the reasons is because of scarring?

A. Yes.

Q. Can you help us understand that scarring?

A. I wasn't able to get any vein penetration because of the scarring on his veins.

Q. Did you have an understanding of how Mr. Crowson developed those scars?

MR. SCHRIEVER: Objection. Speculation.

A. I don't know.

Q. Did you believe it was from heroin use, intravenous drug use?

A. That's normally what we see when someone has been using.

Q. Okay. Do you have any recollection whether those scars appeared to be fresh or older?

A. No, I don't recall.